The Legislative Bulletin

A publication of the Vermont Medical Society

2010 Legislative Wrap-up

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At 12:06 a.m. on the morning of Thursday May 13th, the Vermont General Assembly adjourned for the year after reaching agreement with Governor James Douglas on the budget for state fiscal year 2011.

For the VMS, it was an especially challenging year in its advocacy for Vermont physicians and their patients, due to the continuing impact of the economic downturn on state revenues. In addition, the VMS was actively monitoring the Congressional debate taking place in Washington D.C.

With President Obama signing into law on March 23rd the Patient Protection and Affordable Care Act (PPACA), a new federal framework was established of insurance reform, providing for universal coverage for all Americans and major changes to Medicare and Medicaid. With the federal legislation being phased-in through 2019, there will be an ever-increasing need for the VMS to work to ensure the implementation of health care reform is done in a manner that supports physicians ' ability to make clinical decisions in the best interest of their patients.

Bill allowing for Non-unanimous Jury Verdicts Fails

As reported earlier, S.279, legislation allowing for non-unanimous jury verdicts in civil cases, passed the Vermont Senate by voice vote. However, House leadership indicated to VMS that the bill was a low priority and it was unlikely it would be considered by the House of Representatives before adjournment.

In another effort to secure passage of the legislation, the Senate added the provisions of S.279, as passed by the Senate, to H.470 – the major judiciary restructuring legislation. VMS expressed its opposition to the provision to the House conferees on H.470 and in the final conference agreement the Senate provisions on non-unanimous jury verdicts in civil cases were dropped from the bill.

VMS testified against S.279 due to concern that eliminating the unanimous requirement could lead to an increased number of cases that would otherwise be settled before being bought to trial. VMS also stated that the bill could have a direct impact on the cost of health care, since physicians may order additional diagnostic tests and make additional referrals to other physicians in order to reduce their potential exposure to lawsuits.

The bill, as introduced, eliminated the current standard of unanimous jury verdicts in civil cases and set a new lower 80-percent requirement, thereby allowing verdicts to be decided by 10 of the 12 jury members. However, in recommending the bill for adoption by the full Senate, the Judiciary Committee amended the bill by raising the verdict threshold from ten to eleven out of the twelve jurors, requiring the office of the court administrator to report on the implementation and effects of this act by Jan. 15, 2014; and, repealing the legislation on Jan. 15, 2015.

VMS continued to oppose S.279, since it believes there is not a clear and compelling reason to make the change and due to concerns that the lower verdict threshold has the potential to increase the number of civil cases going to trial.

Contact Us

P.O. Box 1457
Montpelier, Vermont 05601

Toll-Free: 800-640-8767
Fax: 802-223-1201

Online at: www.vtmd.org

Working for Vermont Physicians at the State House

Paul Harrington
Executive Vice President
pharrington@vtmd.org

Madeleine Mongan
Deputy Exec. Vice Pres.
mmongan@vtmd.org

Stephanie Winters
Operations Director
swinters@vtmd.org

2011 Budget Passes Without Cuts to Physician Reimbursement

After lengthy debate and extensive negotiations with the administration designed to avoid a veto, the legislature agreed on a budget for FY 2011. To address a revenue shortfall of $154 million, the appropriations bill, H. 789, balanced the General Fund budget through cuts, government restructuring, labor and retirement savings and changes in revenue.

This year VMS was pleased that the Office of Vermont Health Access (OVHA), soon to become the Department of Vermont Health Access (DVHA), did not propose direct cuts to physician reimbursement, despite the large budget deficit. The administration instead proposed a number of process and service changes including a program of prior authorization for high-tech imaging such as CT scans, MRIs and PET scans. VMS opposed this initiative and shared physicians' comments with legislators. As it became clear that legislators intended to move forward with this proposal VMS worked to ensure that imaging approval guidelines would be available to physicians, that prior authorization responses would be timely, and that OVHA/DVHA would make training available to physicians no later than 60 days prior to implementation of the program. Language was also included that would require OVHA/DVHA to create a physician advisory committee for this program, to create an exemption for physicians whose prior authorization requests are always granted – so-called "gold-card" program – and to ensure timely access to physician peers as part of the process.

Loan repayment for all eligible health care professionals was level funded for next year at a total of $870,000. The loan repayment program for primary care physicians, family physicians, general internists, pediatricians, ob-gyns and psychiatrists, will receive about $445,000. While this amount is insufficient to meet the need for loan repayment, level funding is much better than the 35-percent cut initially proposed by the administration. The Area Health Education Center Program (AHEC) was level funded, despite an initial 50-percent cut proposed by the administration.

A proposed cut of $1.5 million to the tobacco prevention programs was lowered to a $300,00 cut for those programs from last years level.

Pediatric Palliative Care Waiver

The final version of the budget requires OVHA/DVHA to apply to the Center for Medicaid and Medicare Services (CMS) for a waiver that would enable Vermont to reimburse hospice services provided to children with life-limiting illnesses simultaneously with curative care. It is extremely difficult for families who would benefit from hospice services to give up on curative care for their children. In Vermont most of the children who would be eligible for this program have leukemia or other forms of cancer.

Health Care Reform Bill Passes Legislature, Faces Possible Veto

On May 11th, the Senate voted 25-4 to support House amendments to this year's health care reform legislation and send the bill to the Governor for his signature. But the Governor said he doesn't support spending the money to design the bill's three health care models or another provision that would allow the Vermont Attorney General to receive information on free drug samples give to prescribers by the pharmaceutical industry. He stopped short of saying he would veto the bill, saying he needs to weigh the parts of the bill he likes against the parts of the bill he doesn't like.

As reported in the previous legislative bulletin, as it passed the Senate S.88 directed the legislative health care reform commission to contract with a consultant to develop at least three design options for comprehensive healthcare reform in Vermont. Under the bill, one of the options must be for a single-payer plan decoupled from employment. All of the options would be presented to the general assembly for its consideration by February of 2011

The Senate version also established BISHCA-regulated hospital budget targets of a 4-percent increase for rates and a 4.5-percent increase for net patient revenues over the next two years. The House changed the hospital budget targets by eliminating the 4 percent ceiling for rates and replacing it with a broad directive that hospital rates increases must be minimized. The House also changed the hospital net patient revenue figures to 4.5 percent in fiscal year 2011 and a new lower figure of 4 percent in fiscal year 2012.

The House Health Care Committee also added multiple provisions to the Senate passed bill that expand many of Vermont's current health care reform initiatives.

The first section added by the house directs the various branches of state government to take such actions as are necessary to enforce the provisions of the recently enacted federal healthcare reform bill – the Patient Protection and Affordable Care Act of 2010.

The next major section makes numerous amendments to Vermont's chronic care initiative, the Blueprint for Health. The first major change shifts responsibility for the Blueprint from the Department of Health to a renamed Department of Vermont Health Access (DVHA). The logic behind the change appears to be an effort to consolidate many of Vermont's health-care reform efforts at the Department of Vermont Health Access.

The section also includes several provisions related to chronic care management and the medical home and community health teams that are far more detailed and

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Health Care Reform

(cont'd from pg. 2) prescriptive than the current enabling legislation. In opposition to the provisions, VMS cited the importance of allowing physician-led medical homes greater flexibility in designing community health teams in a manner that reflects the unique infrastructure and needs of the various communities around the state.

VMS supported the bill's proposal to make the Blueprint for Health statewide – subject to the full participation of Medicaid, Medicare and the state's three commercial insurance companies, including their self-insured plans.

In an effort to achieve full connectivity to the state's health information exchange network by Vermont's hospitals, the bill establishes a certification process for hospitals that will be linked to the annual hospital budget review process.

One of the most significant provisions in the legislation deals with the development of payment reform pilot projects. Under this provision, a director of payment reform position is created at DHVA. The pilots would be developed in order to address the total costs of the delivery system and improve health outcomes. These systems would be organized around primary care professionals and align with the Blueprint's strategic plan and the statewide health information technology plan. The bill contemplates health insurers, Medicaid, Medicare and all of the payers reimbursing this new entity for coordinated patient care through a single system of payments; a global budget; a system of cost containment, health care outcomes, and patient satisfaction targets.

The section's strategic plan for pilot projects would have the project operational no later than Jan. 1, 2011 with at least two others operational no later than July 1, 2011. The bill reflects VMS's suggestion for the development of a thorough testing of pilots within willing communities to review the concept and ensure it achieves its contemplated benefits.

Aware of Massachusetts' health care reform experience with expanding access and the resulting lack of access to primary care, the committee's amendment also creates a committee to determine what additional primary care capacity will be needed if Vermont achieves universal access, and creates a detailed and targeted five-year strategic plan to ensure an adequate primary care workforce. The committee will have 17 members, including representatives of VMS, the UVM College of Medicine's Office of Primary Care and Area Health Education Centers (AHEC) program, Blueprint, and Bi-State Primary Care Association.

Adjustments to the Pharmaceutical Marketing Disclosure Law - The House Health Care Committee worked closely with VMS on S. 88 to make a number of helpful amendments to last year's pharmaceutical marketing disclosure and gift ban bill.

In order to end the practice of Vermont physicians being banned from partaking in conference meals while attending bona fide educational meetings, the bill allows the sponsor of an event to apply part of the funding to provide meals and other food for all conference participants. In addition, the bill exempts from the gift ban the provision of refreshments at a booth at conferences or seminars. These two amendments track similar revisions in the Massachusetts regulation and were strongly advocated for by VMS. The bill also allows hospital foundations that are organized as a nonprofit entity separate from the hospital to accept funds from pharmaceutical companies in order to conduct CME courses.

With respect to free samples, the bill requires each manufacturer to disclose to the office of the attorney general all free samples of prescribed products provided to health care providers and identify for each sample the product, recipient, number of units, and dosage. However, the manufacturer does not have to report the value of the free sample. The release of any information relating to free samples for research purposes would have the names and license number of the recipients deleted and be subject to confidentiality protections.

Since the Patient Protection and Affordable Care Act of 2010 – the new federal healthcare reform bill – contains a provision requiring manufacturers to report similar information to the U.S. Department of Health and Human Services, VMS was neutral on the issue and did not oppose this provision. In addition, the new provision only becomes operational if the federal government does not provide the Office of the Attorney General research information in a form that can be analyzed.

Finally, the House Health Care Committee's amendment to S.88 mandates insurers to cover dental anesthesia for dental procedures for children who are unable to receive dental treatment in an outpatient setting. It also mandates coverage for approved therapies for tobacco cessation approved by the FDA. At least one insurer in Vermont already covers these services.

S. 88 also included a requirement for restaurants that are part of a chain, with 20 or more locations, to disclose the number of calories contained in the item, and a succinct statement concerning suggested daily caloric intake on their menu and menu board. This act would take effect on January 1, 2001.

For the full text of S.88 as passed, please see *www.leg.state.vt.us.*

Impact of Challenges for Change on the Medicaid Program

A large piece of the budget – the $38 million Challenges for Change government restructuring plan – was addressed separately in H.792, a bill designed to implement this program designed to improve the efficiency and outcomes of government services.
The final version of H.792 includes three Office of Vermont Health Access (OVHA) Medicaid-related initiatives. Section C32 requires OVHA to collaborate with the federally qualified health centers to create urgent care clinics to ensure that non-emergency health services are available outside of hospital emergency departments during evenings and weekends.

Section C33 requires OVHA to redirect funds currently being paid to a private contractor, APS Healthcare, to manage the state's Chronic Care Management Program to instead help fund the local community health teams under the Blueprint for Health. In its testimony, VMS expressed strong support for funding locally based community care teams that would work with primary care physicians, as a part of the patient centered advanced medical home.

Under the second initiative, found in Section C34, OVHA is granted legislative authority to create a Clinical Utilization Review Board (CURB) to examine existing medical services, emerging technologies and relevant evidence-based clinical practice guidelines and make recommendations to the department on the most appropriate mechanisms to implement the recommended clinical practice guidelines. The board is intended to mirror the existing Drug Utilization Review Board and it will be comprised of 10 members with diverse medical experience to be appointed by the governor.

While the final authority for implementing the board's recommendations resides with the director of OHVA, any policies that are inconsistent with the board's recommendations would have to be reviewed by the board prior to implementation.

In its testimony, VMS offered numerous amendments to this program that were accepted. These included moving the focus of the board away from utilization control to one of recommending evidence-based practice guidelines. In addition, VMS was successful in ensuring the board would also be charged to consider the administrative burdens of potential recommendations on health care professionals and also the feasibility of exempting from any prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

To review the full text of H.792, please go to:
http://www.leg.state.vt.us/database/status/status.cfm

Red Flag Rules to Take Effect June 1, 2010

The Federal Trade Commission (FTC) issued regulations in 2007 known as the "Red Flags Rule" that require creditors to implement written identity theft prevention and detection programs to protect consumers from identity theft. The FTC asserts that physicians who bill their patients (including co-payments and co-insurance) are creditors and must comply with the Red Flags Rule. VMS and the AMA disagree with the FTC's interpretation that these rules should apply to physicians. The FTC delayed implementation of these rules several times to allow creditors more time to develop identify theft prevention programs, but no further delay is foreseen and the most recent delay in the compliance deadline expires May 31, 2010.

The AMA has some excellent guidance on this topic on its website. The AMA materials include a guidance document, a sample affidavit, a sample policy, and a FAQ. The Word version of the policy can be adapted for individual practices. *http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/practice-management-center/data-security/red-flags-rule.shtml*

Effort to Tax Supplements Fails

The final version of the H. 783, the miscellaneous tax bill did not include the tax on over-the-counter vitamins and supplements that had been part of an earlier version of the bill. VMS raised concern that taxing supplements that were not prescribed could create a barrier for patients.

Effort to Make it Easier for Out-of-State Physicians to Provide Free Care in Vermont, Process of Granting Pro Bono Licenses to be Evaluated

H. 562 includes a requirement that the department of health evaluate its license requirements and report to the legislature on how to facilitate the license process for physicians licensed in other states who limit their practice in Vermont to providing pro bono services at a free or reduced fee health care clinic. The report is due to the legislature by March of 2011.

BPA Banned in Vermont

A bill (S.247) passed during the legislative session bans the manufacture, sale, and distribution of infant formula or baby food stored in a plastic container, jar, or can that contains bispehnol A (BPA) and the manufacture sale, and distribution of any reusable food or beverage container containing BPA.

BPA is a synthetic estrogen that was originally considered for use in managing challenging pregnancies. Low-dose exposure to BPA has been linked to breast cancer, prostate cancer, recurrent miscarriages, early onset puberty, reduced sperm count, delayed development, heart disease, diabetes, and obesity.

Beginning July 1, 2012, no reusable food or beverage containers, infant formula or baby food stored in a plastic container or jar can be manufactured, sold or distributed in Vermont if it contains BPA. Beginning July 1, 2014, the manufacture sale or distribution of infant formula or baby food stored in a can that contains BPA will be banned.

There was some concern regarding the availability of BPA free containers for use in the WIC program. There is language in the bill that requires the WIC program to report back to the legislature no later than Jan. 15, 2012 with respect to the availability of these products.

The Vermont Medical Society and the American Academy of Pediatrics Vermont Chapter testified in support of the bill.

S. 262 – Coverage of Appropriate Services for Children with Autism Spectrum Disorders

Health insurance plans in Vermont must now cover the diagnosis and treatment of autism spectrum disorders. Coverage must include applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

A health insurance plan shall not limit in any way the number of visits with an autism services provider or will not be able to impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements.

This act shall take effect on July 1, 2011, and shall apply to all health insurance plans on and after July 1, 2011, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than July 1, 2012.

This bill also requires the agencies of administration and of human services and the department of education to evaluate the feasibility and budget impacts of requiring health insurance plans to provide coverage of autism spectrum disorders. The agencies and department will also be required to assess the availability of providers of services across Vermont for individuals with autism spectrum disorders. No later than Jan. 15, 2011, the agencies and department shall report their findings and recommendations regarding expanding coverage and the availability of providers to the house committees on health care and on appropriations and the senate committees on health and welfare and on appropriations.

New Certification Process for Radiologist Assistants Created

H. 562 creates a new certification process for radiologist assistants, similar to the certification requirements now in effect for physician assistants and anesthesiologist assistants. Like physician assistants, radiologist assistants must be employed by radiologists or by the hospital where the radiologist works. Radiologist assistants work under a protocol signed by the supervising radiologist that specifies their scope of work.

The new law spells out in detail the application process for certification, educational requirements, scope of practice and certification fees for radiologist assistants. The law also addresses unprofessional conduct, legal liability, supervision requirements, and includes a requirement that radiologists post a notice if they use radiologist assistants.

This detailed law contrasts with the nursing law, which only includes one sentence authorizing the Board of Nursing to endorse advance practice registered nurses through the rulemaking process. Unlike radiologist and physician assistants, there is no legislative statutory oversight of education, scope of practice or legal liability for APRNs.

APRN Advisory Committee Makes Recommendations on APRN Rules

The Advanced Practice Registered Nurses (APRN) advisory committee reviewed the public comments on the proposed APRN rules at the public hearing in February, including VMS's comments and submitted a chart containing their recommendations to the Vermont Board of Nursing at its May meeting. Their recommendations focus on the four topics that generated the most discussion at the public hearing – education, collaboration, transition to practice (preceptorship) and grandparenting.

With respect to education, the APRN advisory committee recommended eliminating the requirement in the proposed rules for a minimum of 500 hours of supervised clinical training. Instead the advisory committee recommended that educational programs include a clinical component and meet standards set by national specialty certifying boards. The advisory committee expressed support for a provision in the proposed rules opposed by VMS that would eliminate the requirement for a collaborating physician. The advisory committee recommended completely eliminating a provision in the proposed rules that requires new graduates to practice under an on-site APRN or physician preceptor for 1000 hours (six months of 37.5-hour weeks). The committee viewed the preceptorship requirement as a barrier to practice that would limit patient access to care. The APRN advisory committee also viewed the six-month limit on grandparenting in the proposed rules as creating a barrier to recruitment and recommended allowing APRNs to practice independently in Vermont if they met whatever education and practice requirements were in effect as of the date of their graduation. The APRN advisory committee did not recommend adoption of the points made by VMS's members and staff in oral and written comments.

A subcommittee of the Board of Nursing (not the APRN advisory committee) will meet sometime in the next two months, discuss the proposed rules and the APRN advisory committee's recommendations and bring another proposal to the full board at the July 12 board meeting. It is not clear whether the board will adopt the recommendations of the APRN advisory committee. For example, board members indicated some support, at least in concept, for the preceptorship with an APRN or physician being required for new graduates. The Board discussed not requiring the preceptor to be on-site with the new APRN graduate, however.

For more information about the proposed APRN rules, the Advisory Committee grid, VMS's comments, VMS's policy, and the comments of the Vermont Board of Medical Practice (VBMP), see *http://www.vtmd.org/APRN/APRN%20Index.html.*

The Vermont Medical Society is the leading voice of physicians in the state and is dedicated to advancing the practice of medicine by advocating on behalf of Vermont's doctors and the patients and communities they care for.

Medicare Timely Filing Window Reduced to 12 Monthswindow reduced to 12 months

The Centers for Medicare & Medicaid Services has reduced to 12 months the deadline by which physicians may submit Medicare claims for service provided to Medicare beneficiaries.

As a result of the Patient Protection and Affordable Care Act (PPACA), claims with dates of service on or after Jan. 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. Additionally, Section 6404 of PPACA mandates that all claims for services furnished prior to Jan. 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than Dec. 31, 2010.

Medicare contractors are adjusting their relevant system edits to ensure that:

- Claims with dates of service prior to Oct. 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service Oct. 1, 2009 through Dec. 31, 2009 received after Dec. 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service Jan. 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

NOTE: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

For more information, please go to: *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*

VMS 2010 Physician Survey

Each year, the Vermont Medical Society conducts a survey to help ensure that the work of the society reflects the concerns and priorities of our state's physicians. We hope you will take the time to complete thus year's survey and help to ensure that we receive as large a response as possible. Please feel free to share this survey with your physician colleagues.

The following is the link to this year's survey: *http://www.surveymonkey.com/s/vms2010survey.*

Like previous surveys, it has three areas of questions, as well as asking for some demographic information. The first section on "satisfaction with your practice and health determinants" is very similar to the questions we asked last year and they should provide the VMS with a baseline to track this information into the future. The second section asks questions relating to federal health care initiatives.

The last set of questions relate to issues the VMS anticipates will be considered by the General Assembly next year and they could lend themselves to becoming VMS policy resolutions for consideration at our November 6th annual meeting.

During testimony this legislative session, last year's survey was frequently cited as the basis for the society's resolutions and policies. From these experiences it is clear that the survey results add additional credibility to the VMS's advocacy efforts on behalf of all Vermont's physicians.

Please complete your survey no later than June 7th, so the results can be used to inform the VMS Council's deliberations during the VMS's 2011 priority setting retreat on June19th

Please let Stephanie Winters know if you have any questions or suggestions by calling 800 640-8767 or by e-mailing: swinters@vtmd.org.

Unique IDs to replace Social Security numbers for claims and ID cards

Unique identification numbers (UID) will be used for each beneficiary starting October 1, 2010. The UID will help protect our members' personal information by removing Social Security numbers currently used on ID cards and claims submissions.

New health plan ID cards will be mailed to all beneficiaries in September; however, **do not begin billing with the new ID number until October 1**.

To facilitate this transition, our automated eligibility verification systems will allow providers to check eligibility using a Social Security number or the unique ID number. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim

- Online Transaction Services - *http://www.vtmedicaid.com/Interactive/login2.html*
- HP Voice Response System/Malcolm - 1-800-925-1706 (instate) or 802-878-7871.

The OVHA will be communicating the change to providers and beneficiaries in various ways over the next several months. The next edition of The Advisory *http://www.vtmedicaid.com/Downloads/bulletins.html* will include a small poster about the new UID cards. We would appreciate your help by displaying the poster.

Stop the Medicare Meltdown petition

Led by the Texas Medical Association, a number of state and county medical societies are embarking on a campaign to gather 1 million signatures to stop the Medicare meltdown being created by the flawed Sustainable Growth Rate (SGR) payment formula. The groups are asking physicians, senior citizens and other community groups to sign the Stop the Medicare Meltdown petition. The petition can be found at: *www.ipetitions.com/petition/meltdown* - just add your name, city and state, then hit the "sign" button. The list of names signing the petition will be delivered to Congress.

VITL Sponsors E-Prescribing Interprofessional Workshop

To register for this free workshop, go to *http://www.eventbrite.com/event/614909210*

Thank you to all of our members and partners for the input, testimony and calls you made this legislative session to help improve the quality of health care in the state of Vermont.

The VMS staff are grateful and appreciative for all that you do!

To view the full text of any of the bills discussed in this issue go to:
http://www.leg.state.vt.us/database/status/status.cfm
Type in the bill number and click on the "As passed both House and Senate" version.

SAVE THE DATE
Vermont Medical Society 197th Annual Meeting

Saturday, November 6, 2010
The Equinox Resort, Manchester, Vermont

Make your reservations today! Call 1-877-854-7625.
Room Block Deadline is October 6, 2010
Make sure you tell them you are with the VMS

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